

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	A designated centre for people with disabilities operated by Peter Bradley Foundation Limited
<b>Centre ID:</b>	OSV-0001522
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Peter Bradley Foundation Limited
<b>Provider Nominee:</b>	Stevan Orme
<b>Lead inspector:</b>	Mary O'Mahony
<b>Support inspector(s):</b>	Aoife Fleming
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	5
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

**Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
19 February 2015 09:30	19 February 2015 18:00
20 February 2015 09:30	20 February 2015 20:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

The Health Information and Quality Authority's (HIQA or the Authority) second inspection of this centre was announced. As part of this registration inspection, inspectors met with all residents, the person in charge, the area manager, the social care leader and rehabilitation assistants. Inspectors spoke with the person in charge and discussed the management and governance arrangements for supporting staff in their roles. Inspectors reviewed the policies and procedures in the centre and examined documentation which covered issues such as medication management, accidents and incidents, personal plans, staff files, policies and training records.

The person in charge informed inspectors that she endeavoured to provide a person-centred service to effectively meet the needs of residents. On the two days of inspection there were five residents in the centre. While the inspection was in progress the residents were seen to be going out to attend appointments, to go to various centres for their rehabilitative programmes and to be engaged in their various allocated duties in the house.

The centre was located in a quiet residential estate and the house was a dormer type bungalow. Residents were involved in maintaining the outside area and there was a shed, a smoking area and a large patio table in the garden. The person in charge informed inspectors that one resident paints the outdoor furniture on a yearly basis and that she had plans to purchase new outdoor chairs for the spring and summer. Residents were engaged in art classes and inspectors observed colourful collage and paintings by residents displayed on the walls.

The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. Improvements were required in the areas of notifications, medication management, health and safety and risk management, fire safety, premises, staff training, as well as policy updates.

Since the inspection the centre has received notice that their application and funding for a newly built residence will be forthcoming.

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

**Outcome 01: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors noted that the rights of residents were supported by staff in the centre. There was a regular consultation process in place which the person in charge said was adapted to residents' needs. The person in charge explained how residents accessed advocacy services. The previous inspection report had been read with the residents and this was documented. The person in charge said that residents had been informed about the registration inspection process and inspectors noted that this discussion was documented in the minutes of residents' meetings. Residents were aware that inspectors were on the premises and were willing to speak with them.

A notice board containing information in an accessible format was displayed in the hallway. This included information on how to make a complaint, residents' rights, access to advocacy, the Resident's Guide and the statement of purpose. There was also pictorial input in documents seen by inspectors. A staff member with whom inspectors spoke said that residents and their representatives were involved in formulating personal plans. Residents could make choices about their daily lives with support from staff. Staff with whom inspectors spoke were aware of the residents' likes and dislikes. The staff roster was available for viewing by inspectors and this indicated continuity of staff in the centre. The provider had developed policies to guide staff on the care of residents' property and money management, as required by Regulations. The person in charge informed inspectors that personal belongings were listed and signed by the resident. However, the policy was not updated since 2009. This will be addressed under Outcome 18: Records and documentation. Consent forms were signed for medication administration, photographs and financial transactions. This documentation was reviewed by inspectors.

Residents were enabled to access local amenities such as the library, bridge clubs, shops, restaurants and hairdressing facilities. Residents were facilitated to go for walks or drives and to take part in arts and crafts, multi-sensory sessions and support groups among other interests. Residents were also supported to attend religious ceremonies of their choice. Some residents walked to mass independently. Day trips and overnight outings, which were in line with their individual assessed needs, were arranged. Residents had access to personal transport that was driven by appropriately qualified staff. However, occasional staff shortages impeded all residents from attending various events in which they had expressed an interest and this also impacted on achieving some of their goals. Residents spoke about this with inspectors and this issue was addressed under Outcome 17: Workforce.

There was a complaints policy in operation in the centre. However, the policy was not localised and did not refer to local complaints management personnel by name. This issue will be addressed under Outcome 18: Records and Documentation. An easy-to-read version of the complaints procedure for residents and their representatives was prominently located in the entrance hall. The name of an independent nominated person was displayed. Staff and residents with whom inspectors spoke were aware of how to initiate the process. Inspectors noted a number of complaints about conflict in the house and outside of the house however, inspectors noted that these were not always followed up with a risk assessment. In addition, the outcome and the satisfaction or not of the complainant was not always recorded. Inspectors viewed a complaint about accessibility issues for wheelchairs in the house which had not been resolved. Inspectors observed that the house was not wheelchair friendly and one resident stated to inspectors that he could not easily manipulate the doorways with his wheelchair. In addition, the house was situated on a hill so he could not access the local town without transport. Furthermore, inspectors noted a complaint about lack of staff in the complaints log.

The centre had five residents' bedrooms and one staff bedroom. There were large wardrobes, shelving and locked storage facilities available for each resident. There were two 'sleepover' staff on duty each night. One staff member slept over in the sitting room from 23.30hrs. This arrangement impacted on the residents' access to the sitting room from 23.00 onwards. There was no separate visitors' room. However, the person in charge stated that visitors used the sitting room if a private visit was required during the day. This limited space for remaining residents as there was one other communal room in the house which was an open plan dining room/ kitchen.

**Judgment:**

Non Compliant - Moderate

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**

Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found that staff were aware of the communication needs of residents and the care plans reviewed indicated that communication needs were being met with support from the advocacy, social work and speech and language therapy (SALT) services. The residents' representatives were consulted in the formulation of plans where appropriate. Plans of care outlined specific means of communication and were seen to be detailed, including information such as how residents expressed different emotions through their behaviour. There was evidence that multi-disciplinary professional input was sought where required. For example from psychologists, psychiatrists and the general practitioner (GP). However, the person in charge stated that she had difficulties gaining sufficient access to the primary care team particularly the occupational therapists (OT) for residents needs. There were televisions, DVD players and radios available to residents. Some residents had their own phones and the use of mobile phones was encouraged. Pictorial prompts were used on notices where required.

The psychologist provided advice and detailed steps to be followed when providing positive behaviour support. Inspectors saw that this information was included in the personal plans for the attention of staff. Friends and relatives were encouraged to visit the centre and residents spoke with inspectors about these visits.

**Judgment:**

Compliant

**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**

Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found that the centre supported and encouraged positive relationships between residents and family members. An open door visiting policy was in place in the house with family and friends visited facilitated. However, residents could not always be facilitated to meet with visitors in private, other than in their bedroom. Inspectors saw that staff had access to phone numbers of family representatives, and other relevant people.

Residents were facilitated to undertake home visits. Residents' families were facilitated to take them shopping, to restaurants or other social occasions. Residents spoke with inspectors of their close links with family and friends. The person in charge informed inspectors that family and friends were encouraged to visit on special occasions such as Christmas parties. Inspectors noted that residents had photographs of family and friends on display in their bedrooms. Staff were seen to facilitate residents going to local shops, gyms and meeting with family members throughout the two days of the inspection. Some residents attended day services such as Headway, Brí and Cúnamh to support their individual needs.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**

Effective Services

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found that the process of admissions was in line with details in the statement of purpose. Contracts of care set out the service to be provided in the designated centre and were signed for each resident. Contracts of care set out the fees for services, however, additional charges were not included.

Transfers and admissions were set out in the admissions policy which also addressed transfers and discharges. However, the admissions policy did not set out criteria to protect residents from peer abuse as required by Regulation 24 (1) (b).

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between*



**Theme:**

Effective Services

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Residents' wellbeing and welfare were maintained by a high standard of evidence based care and support. Residents were facilitated to participate in meaningful activities appropriate to their interests and preferences. Inspectors saw that individual rehabilitation plans (IRPs) were in place and staff and residents spoken with outlined that these were developed in consultation with residents. The IRPs were conducted at least annually and outlined each resident's health, personal and social care goals. A weekly rehabilitation timetable was in place for each resident and was developed in consultation with each resident.

Residents' personal plans (PCPs) contained relevant and up to date information on personal care plans, a detailed end-of-life care plan and support with money management care plan. Inspectors spoke with residents who informed them that there were a number of options available to them in relation to activities and work. Inspectors noted that residents were involved in the organisation of the daily routine in the centre as they were involved in cooking and doing their own laundry. The PCPs were accessible to residents.

Visits to the local town were facilitated by car or by foot, either independently or with a staff member as appropriate. However, for residents who were not independently mobile, the location at the top of a steep hill meant that transport by car was often required. In addition, two residents had recently left the centre unnoticed and walked down the hill. Two residents had been involved in altercation with members of the public and documentation on these was reviewed by inspectors. Incidents of absconsion had not all been notified to the Authority and these will be addressed in more detail under Outcome 9: Notifications. These incidents had not all been suitably risk assessed and appropriate controls had not been put in place to prevent a recurrence for all residents involved. The issue of lack of robust risk assessment will be addressed under Outcome 7: Health and safety and risk management.

Residents spoke with inspectors and outlined the variety of off-site activities which they enjoyed such as shopping, bridge, men's shed, art and attending training workshops. Life skills training was provided in the centre, for example home management, hand hygiene and emergency response training.

**Judgment:**

Compliant

**Outcome 06: Safe and suitable premises**

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**

Effective Services

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors noted that the centre was clean, comfortable and homely and the furniture and fittings were of a good standard. There were four bedrooms and a bathroom downstairs and one of these bedrooms had an en suite facility. Upstairs there was one resident's bedroom, a bathroom and a staff bedroom located off the staff office. There was an assisted shower chair stored in the hallway downstairs. The person in charge said that this was to be returned to the company. This chair restricted the space in the hallway. Inspectors observed that corridors and doorways were narrow and the centre was not suitable for all residents. For example, the narrow doorways and corridors were not suitable for one resident who required a wheelchair. In addition, the narrow hallways impacted on residents with behaviour difficulties as there was little space to pass other residents. Inspectors noted incidents of peer altercations in the corridor. Furthermore, there was a stair gate at the end of the stairs which the person in charge said was there to prevent some residents accessing the upstairs area and for safety reasons. One resident residing upstairs had said she was apprehensive about the behaviour of one of the male residents. Inspectors observed that this gate was open during the inspection and a male resident who did not reside upstairs, was seen to be using the upstairs bathroom. There was a wheelchair ramp outside the front door but the resident who used a wheelchair could not go out independently due to the steep slope on the hill.

Inspectors spoke with the regional manager of the centre who stated that the organisation had made six applications to the local county council for a suitable site to build a new purpose built centre. She stated that the present house was rented and not suitable for all residents' needs. She outlined how this was not the case in other geographical areas where permission was granted promptly and new centres had been built. The person in charge also stated to inspectors that she had been strongly advocating for a new centre for an extended period of time. However, resources were restricted and this limited residents' outings. Necessary funds had not been made available to her. She explained that the centre was part funded by the health services executive (HSE) and partly by fund raising. The only option open to a resident in Cork, who does not want to reside in this area is to move to a nursing home nearer to their home, where their rehabilitative plan would no longer be ably supported.

There were sufficient toilets and showers in the centre, however because of the physical requirements of residents' en suite facilities would have met their needs in a manner

that promoted enhanced privacy and dignity. In addition there was no bath in the centre. Inspectors noted that there was a loose tile in front of the upstairs toilet which was a trip hazard. Inspectors viewed an incident where a resident had fallen in this bathroom. Furthermore, the downstairs toilet and shower room had a strong unpleasant odour and did not appear clean as regards stains on the floor and dust on surfaces. The shower up-risers in two showers were noticed to be rusty and there was a dirty shower mat in the downstairs shower room. The soap dispenser in this toilet area could not be operated.

There was a communal sitting room and dining room/ kitchen area in the centre. However, inspectors formed the view that this space was inadequate for these residents. Due to complex needs and their differing personalities they required more private space and recreational space outside of their bedroom.

Inspectors noted that there was some painting required on the ceiling in the bedroom and kitchen which was attended to on the first day of the inspection. In addition, the woodwork in the centre required repainting due to the damage from the wheelchair on the narrow door frames.

Areas where hazards were present were not all restricted as outlined under Outcome 7. Hazards which had not been identified and risk assessed will be listed under Outcome 7 also : Health and Safety and Risk Management.

**Judgment:**

Non Compliant - Major

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Risks not addressed since the last inspection included:

All risks in the centre had not been identified and assessed. The risk management policy did not specify the controls in place to minimise the risk of the unexplained absence of a resident.

The risk management policy did not outline the measures in place to control and minimise aggression and violence.

The risk management policy did not list the controls in place for the prevention of self-harm.

The risk management policy did not specify the controls in place to minimise the risk of

the unexplained absence of a resident.

There was no fire panel to support staff in locating the source of a fire.

The centre did not have a fire compliance certificate available from a suitably qualified person in the area of fire safety.

Fire prevention precautions and controls for non-compliant smokers needed to be more robust in the area of supervision, location of cigarettes, furnishing and bedding.

Findings on this inspection:

The centre had a health and safety statement and it was relevant to the centre. It was reviewed in 2015. There was a health and safety committee which met on a monthly basis and inspectors read the minutes of these meetings. There was a regular audit of health and safety issues in the centre and the centre had the services of a health and safety representative.

Procedures were in place for the prevention and control of infection. However, these were not robust. Alcohol hand gels and disposable latex gloves were available. However, not all the latex gloves were stored safely. In addition, a resident who was responsible for cleaning his own shower and bathroom area had the mop for this stored in his shower room. The guidelines for cleaning and prevention of cross contamination from a particular ongoing infection, were seen to be dated 2011. Furthermore, inspectors observed that kitchen mops were stored in water outside the back door. Alginate bags were available for the segregation of laundry in the event of an outbreak of infection. Housekeeping and laundry duties were carried out by the staff and residents in the centre and the laundry was equipped for the needs of the centre.

The centre had a risk management policy and a risk register which captured some potential risks (environmental, operational and clinical) associated with the centre. There were some measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents, such as the health and safety meeting. Staff informed inspectors that incidents and adverse events were also discussed at staff meetings. Inspectors viewed minutes of these meetings.

However, not all risks in the centre had been identified and assessed and the risk register did not contain the controls in place to eliminate or minimise these risks. These included the open front door, a lighted candle in one bedroom, the use of a hot water bottle, the access to the outside smoking area at night, the storage of vinyl gloves, open presses containing chemicals, infection control procedures for washing kitchen and bathroom floors particularly in the presence of an infection and the presence of sleeping staff only at night. Nevertheless, there were coloured coded systems in use for floor washing and food preparation. The person in charge said that senior staff had received training in food safety and that all staff were given instruction on safe food preparation, hand hygiene and food storage during their induction training. There was a labelling system in place for any food which was being stored in the fridge. Inspectors observed that there was a new freezer in the kitchen since the last inspection.

There was documentation available in the centre which indicated to inspectors that there were discussions about serious incidents/adverse events involving residents at the handover meetings. However, inspectors observed that there was no record, in the case of an absconion, in the nursing notes or of the learning which had taken place as a

result of the incident. The risk management policy did not outline the controls in place for the risks which were specified under Regulation 26 (c) similar to findings on the previous inspection. There was still no call bell available in the bathrooms. A further risk which required assessment and controls was the risk of a resident falling during the night while the staff were sleeping. The downstairs bathroom was in need of cleaning and some repairs were necessary to maintain a safe and hygienic environment. There was no separate staff toilet and changing area for the two sleepover staff. Taking into consideration the needs of residents and the presence of an infection in the centre inspectors formed the view that separate facilities were necessary for staff, for infection control purposes as well as for the privacy and dignity of residents.

An emergency plan was in place in the centre and a safe placement for residents in the event of an evacuation had been identified. Regular fire drill training was documented and there were personal evacuation plans for residents. Records reviewed by inspectors indicated that the emergency lighting as serviced on a quarterly basis and fire safety equipment was serviced. There was evidence that arrangements were in place for daily checking of fire precautions which included the fire exits. Residents tested smoke alarms weekly. Inspectors noted that fire exits were unobstructed. Staff spoken with by inspectors were aware of what to do in the event of a fire. The procedure was also displayed in the hallways to increase awareness.

Residents had individual fire evacuation and emergency plans (PEEPS) on display in their bedrooms. Inspectors noted that there were not sufficient smoke alarms in the upstairs staff office and bedroom area, the sitting room and in the bedrooms of residents who smoked. These were put in place while the inspection was in progress. There was no centralised fire alarm system in place. This was particularly significant as inspectors noted that there had been incidents of residents smoking in their bedrooms despite a risk assessment plan that had been put in place for residents requiring them to leave their cigarettes in the hall at night. On the previous inspection this had been discussed in detail with the person in charge who was asked to risk assess the practice and put safe controls in place to protect all residents from fire. The assessment had been carried out, however the cigarettes and lighters remained in the hall at night, accessible to residents. Staff at night were on sleep over duty and there was no smoke alarm in either of the staff sleeping areas until inspectors pointed this out to the person in charge. Inspectors noted that one staff member had smelled cigarette smoke in a resident's bedroom on 11 July 2014 at 22.00. A second incident had been recorded on 17 September 2014 where a resident took his cigarettes into his room and would not leave them in the tray in the hall. A further incident was recorded on 16 June 2014 where smoking burns were noticed on the mattress and sheets of one residents' bed. However, this significant risk presented by residents who smoked did not have sufficient controls in place at the time of inspection, despite it being highlighted by the inspector on the initial inspection in June 2014. Furthermore, was dated on the action plan submitted to the Authority following that inspection as for review on 31 August 2014.

Inspectors spoke with the person in charge about the absconion of residents which had occurred unnoticed by staff on two occasions. However, these incidents had not been notified to the Authority as required by the Regulations. This was done retrospectively. One incident involved a resident that left the house in the afternoon and became involved in an incident in a local shop. He was noticed in that vicinity by a staff member

who was driving other residents back to the centre. The two staff on duty in the house that afternoon were not aware that he had gone down the hill unaccompanied, even though he had been previously risk assessed as requiring staff support when going out. A second resident had gone out at night at 23.30 without the knowledge of staff, who had gone to bed. He was not noticed to be missing until he returned to the centre at 01.00 and rang the door bell. However, controls in the centre had not been reviewed or updated as a result of these events. In addition, the policy on 'Missing Persons' was dated 2010. Furthermore, residents went outside during the night to the back garden shelter to smoke while staff were sleeping. This arrangement had not been comprehensively risk assessed for example, unsupervised night time smoking, environmental risks, the possibility of the doors being left open and other more immediate risks.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe Services

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The person in charge informed inspectors that she was actively involved in the management of the centre. There was also a social care leader who was on duty each day. They expressed confidence in the safety of residents through speaking with residents and their family members and observing interactions with staff. The person in charge stated that she was aware of her obligation to report any allegation of abuse to

the Authority.

Residents spoken with by inspectors said that the staff were generally caring and inspectors observed interactions between staff and residents which demonstrated a respectful attitude. They said they felt safe in the centre. However, one resident stated that at times he did not feel safe. Another resident told inspectors that a particular staff member does not always speak in a kind tone of voice to him. Residents were afforded privacy to speak with inspectors throughout the inspection. One staff member stated to inspectors that staff can sometimes be bossy towards the 'lads'. These issues were discussed with the person in charge at the feedback meeting and reassurances were provided to the Authority that the person in charge would speak with the residents involved following the inspection. The person in charge was asked to forward safeguarding plans for these residents following the inspection.

There was a policy on the management of allegations of abuse however, this was in need of review as it was dated 2011. There was a named person identified as the person responsible for investigating allegations and the responsibility to report any allegation to the Authority was documented. The person in charge informed inspectors that staff were reading the new HSE guidelines for the safeguarding of vulnerable persons at risk published in December 2014. Inspectors noted that staff had signed to indicate that they had read this document which was on display in the staff room. Training records indicated that most of the staff had received training on the prevention and detection of abuse. However, one staff member informed inspectors that she had not had training but instead she took part in a discussion, at a staff meeting, on the issue. Residents were aware of the name of key workers and understood that they could access an advocate and were familiar with the concept of advocacy. There was a folder on advocacy services on the table in the sitting room.

There was a policy on restrictive interventions which outlined measures to promote a restraint free environment. The policy listed alternative measures to the use of restraint. A number of staff had received training in positive behaviour support. The person in charge informed inspectors that all training was reviewed annually. There was also a policy on behaviour that challenges and this contained details of support for both residents and staff in understanding behaviour issues. However, not all staff had received training or updated training in the prevention and de-escalation of behaviour that challenges. Staff spoken with by inspectors outlined an incident which occurred in a shopping centre which left them feeling "afraid". Staff stated that they did not receive a sufficient debriefing session following the incident, which was prolonged. One staff member stated that training on managing "violent" behaviour was needed for staff. One resident informed staff that he was apprehensive of another resident's behaviour. Inspectors found that the measures in place for the management of residents' finances were not robust. Records were made of transactions conducted by and on behalf of residents however, they were not always signed by two staff members or by the resident and one staff member. In addition, receipts to support the expenses incurred by residents for holidays, that had been taken when accompanied by staff, were not all accounted for. Residents had been documented as paying for a portion of staff members expenses when accompanying them on holidays. Furthermore, inspectors noted that residents had receipts for pharmacy supplies which were not itemised. Residents in general, had control over their finances and were appropriately supported in budgeting

their finances by staff members.

**Judgment:**

Non Compliant - Major

**Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Services

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

A record of all incidents occurring in the centre was maintained. However, all notifications as regards allegations of abuse and residents unexplained absence from the centre were not being notified to the chief inspector in line with Regulations. The person in charge forwarded NF05 notifications on unexplained absence of residents, in retrospect, following the inspection. Quarterly reports were provided to the Authority and inspectors viewed these prior to this inspection.

**Judgment:**

Non Compliant - Major

**Outcome 10. General Welfare and Development**

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**

Health and Development

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Residents opportunities for new experiences, social participation, education and training were facilitated and supported. An assessment of each resident's goals, accounting for their abilities and interests, had been completed in the IRP.

Evidence of FETAC training courses undertaken by residents in art, fire training and safe



food preparation were seen in the centre. Certificates and photographs of educational and training achievements were displayed. The person in charge identified that there were challenges in securing support from organisations in order to meet the educational and training goals for some residents. The staff spoke of their on-going efforts to access support from day services such as Headway and Mens' Shed for the residents to promote their development.

The person in charge identified the importance of including the residents in the community. Residents were facilitated in this regard by attending local activities in the community and doing daily shopping. Residents' independence was promoted in the centre as they were observed helping to cook meals and undertake daily activities such as doing their own laundry and cleaning.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Residents had access to general practitioner (GP) services and appropriate therapies such as dietician, podiatry, physiotherapy, and dentist. There was evidence in residents' notes that access to specialist consultants was organised and facilitated to meet the medical needs of the residents. However, the person in charge stated to inspectors that access to the occupational therapist (OT), speech and language therapist (SALT) and the psychologist was limited and said that this impacted negatively on the wellbeing of residents'. One resident expressed a wish to inspectors to see the social worker and the OT. This was referred to the person in charge. Some staff members informed inspectors that they helped a resident with his speech and language exercises as advised by the SALT. However, this was not documented as happening regularly and was dependent on the staff member on duty and the availability of staff.

The centre focused on neuro-rehabilitation and staff spoken with by inspectors explained that residents had an IRP which was reviewed annually and more often when required. Residents were supported to identify and fulfil their goals by their key-worker, who was their rehabilitation assistant. Documentation to support this was viewed by inspectors. There were two residents in the centre who would like to move to a centre near their home. However, the person in charge outlined to inspectors that resources and planning were not forthcoming, to provide a second house in the Cork area.

Inspectors noted that residents were supported to make healthy living choices. Visits to the gym were facilitated by staff and healthy eating plans were in place for some residents, as recommended by the dietician. Adequate stores of fresh and frozen food, refreshments and snacks were in place in the kitchen. Residents informed inspectors that there was a choice available to them and that menu plans for the week were developed on a Sunday, in consultation with residents. Some residents shopped independently. Residents' meal times were facilitated, based on their own personal preference. Meal times were noted to be a positive and social event in the centre. Inspectors observed that staff were aware of the healthcare and social needs of residents in the centre. The individual routines and supports required by residents were outlined and documented in detail. A detailed end of life care plan was completed for each resident and documented in their notes.

However, inspectors noted that a behaviour intervention plan for one resident had not been updated since 2011. In addition, the person in charge stated that some of residents were not getting the supports they required from allied services. Furthermore, all residents in the house attended one GP.

**Judgment:**

Substantially Compliant

**Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**

Health and Development

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The medication management policy was up to date, however, it was not centre-specific. This will be addressed under Outcome 18: Records and documentation to be kept in the centre. In addition, not all staff spoken with by inspectors had training in the administration of buccal midazolam for the management of seizure activity.

Since the previous inspection a storage cabinet had been installed for storage of unused and out of date medicines awaiting return to the pharmacy. However, some medications which had expired were stored in the residents' medication press. A number of medications in the residents' medication press, such as tubes of cream and loose tablets in a bottle, were stored without an expiry date and without a recorded date of opening. Inspectors observed that psychotropic medication was stored in a box which had a current date on the outside. However, one strip of medications inside the box was noted to be out of date. This was shown to a member of staff. These errors had not been

identified or recorded. This will be addressed under Outcome 18: Records and documentation.

Medications were supplied by the pharmacy in blister pack systems and regular reviews of prescriptions by the GP were apparent in residents' care plans. Inspectors noted that a medication administration and prescription booklet were in place for each resident. Photographic identification was in place for each resident. There was a tablet identification sheet for all medications administered. Protocols for the administration of PRN (as required) medications were in place in the residents' prescription folder. Seizure records and a portable medical profile, to support hospital admission were in place, where appropriate. Residents were facilitated to meet with the pharmacist on their visit to the pharmacy to collect their medication.

One resident was responsible for the self-administration of their 13.00 medications. An appropriate risk assessment had been conducted and a weekly review was conducted by staff with the resident.

Incidents of medications being found on the floor were recorded on a number of occasions and the personal medication plan for one resident was reviewed to ensure that they were observed taking their medications. However, there were errors noted again following this review. Inspectors reviewed medication audit reports conducted in the centre. However, there was no evidence to support the learning from the audits in order to reduce medication error incidence. For example, missed doses of medication in the centre or when out on home visits were not addressed in the audit report. These concerned vital medicines. There was no evidence in one case that the resident had been reviewed by the GP following incidents of missed medications. This pattern of missed medication was not reflected in the resident's personal plan and there was no risk assessment carried out to mitigate any risks.

**Judgment:**

Non Compliant - Major

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The centre had a statement of purpose that accurately described the services provided. It contained most of the information required under Schedule 1 of the Regulations. The

statement of purpose was kept under review and was available and accessible to residents. However, the statement of purpose required to be updated as the fees paid by residents had increased by 10 euro. This update was done while inspectors were on the premises.

There was not sufficient information in the statement of purpose on the complaints process in the centre.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**

Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There was a governance and management structure in place which was in accordance with the structure outlined in the statement of purpose. The person in charge was engaged in the governance, operational management and administration of the centre. She attended the centre on two or three days weekly. She was also employed in other management duties with the organisation in the Cork-Kerry region. She had the support of the social care leader who was employed in the centre on a full time basis. Inspectors spoke with the regional manager who demonstrated detailed knowledge of the operation of the centre.

The person in charge demonstrated sufficient knowledge of the legislation and of the statutory responsibilities. Residents were able to identify her as the person in charge and they informed inspectors that she was approachable and supportive. The leadership and organisational skills of the person in charge were demonstrated by the easy accessibility of documents in the centre.

An annual review of the quality and safety of care and support was conducted in the centre. This had been last conducted in November 2014 and the actions emerging from the review were being addressed by the person in charge.

The regional manager informed inspectors that she made unannounced visits to the

centre. Documentary evidence to support these visits and the report on the annual review were made available to inspectors.

**Judgment:**

Compliant

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There were arrangements in place for the management of the designated centre in the absence of the person in charge. A suitably qualified social care leader had been identified to deputise in her absence. The provider was aware of the responsibility to notify the Authority, within the specified time frames, of the absence of the person in charge.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Every effort was made by staff to support residents to meet their goals, go on holidays, visit their homes and go to various activities and concerts. However, the person in charge identified that there were challenges in securing funding to support residents achieving their individual personal goals and access to external supportive services was limited for some residents.

Inspectors noted that facilities and services available in the centre reflected those outlined in the statement of purpose. Sufficient staff were noted to be present during the inspection to support residents with their daily needs and activities. However, staff with whom inspectors spoke stated that some residents did not get out often enough, in particular one resident who only went out of the centre on average for two hours a week. In addition, there was occasionally only one staff member on duty at weekends if the second staff member went on sick leave. This limited residents' ability to go on weekend trips if that was their preference.

If residents wanted go to a concert they contributed towards the cost of the staff member who accompanied them and inspectors saw documentation confirming this on two recorded occasions.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**

Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

A sample of staff files reviewed by inspectors complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. Staff files were maintained in good order. Inspectors viewed the policies on staff recruitment and saw that staff had fulfilled the required vetting procedures. Records reviewed indicated that most staff had attended a range of training to include the mandatory training required by Regulations. The person in charge informed inspectors that training needs of staff were assessed annually and that training could also be provided on an individual basis if the need arose. However, not all staff had appropriate training relevant to their role. For example, not all staff were trained in positive behavioural support, the administration of buccal midazolam and the prevention of abuse. This was addressed under Outcome 8: Safeguarding and safety.

Staff were supervised according to their role. Rosters were planned to meet the needs of the residents. Inspectors viewed the worked roster and planned roster. Staff were

able to demonstrate an awareness of the centre's policies and had access to a copy of the Regulations and the National Standards. There was continuity of rehabilitation staff for the residents and staff with whom inspectors spoke were qualified and experienced. Supervision, probationary meetings and appraisal of staff were ongoing according to the person in charge. All staff members had five supervision sessions in the year. Supervision documentation was reviewed by inspectors.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**

Use of Information

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The majority of records listed under Part 6 of the Health act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were maintained in the centre. However, some records required, were not available. For example, all medication errors had not been recorded, not all drugs were signed as administered or gaps accounted for. Accurate records of charges to residents were not maintained. In addition, notifications of absence of a resident from the centre and notifications of an allegation of verbal abuse had not been made to the Authority and records of these were not available.

The designated centre was adequately insured against accidents or injury to staff, residents and visitors. This document was viewed by inspectors.

The centre had policies in place as required under Schedule 5 of the Regulations. However, not all policies and procedures had been reviewed and updated, to reflect best practice, at intervals of not less than three years, as required. Examples of these were the policy on protection of vulnerable adults (2011): the policy on resident's finances (2009): the missing persons' policy (2010): infection control guidelines (2008) a new policy was in draft form, dated 2015; guidelines on a specified infection (2011). However, the HSE guidelines on infection control were available in the centre and the

new HSE protection guidelines for vulnerable adults 2014 were available and read by all staff. The regional manager indicated that the centre's policy on protecting vulnerable adults would be updated in line with these guidelines. In addition, not all policies were centre specific, such as, the complaints policy and the medication policy.

**Judgment:**

Non Compliant - Major

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

***Report Compiled by:***

Mary O'Mahony  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority



## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Peter Bradley Foundation Limited
<b>Centre ID:</b>	OSV-0001522
<b>Date of Inspection:</b>	19 & 20 February 2015
<b>Date of response:</b>	23 July 2015

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Each resident's privacy and dignity was not respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

For example:

-There was no separate visitors room available.

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

-A resident who resided upstairs did not always have personal space protected as other residents would go upstairs even though there was a stairs gate in situ.  
-There was no access to the sitting room for residents after 23.00hrs.

**Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**

1. Funding application to Cork County Council (Capital Assistance Scheme)
2. Meeting with ABI Ireland Property Manager on accommodation options & funding

Proposed Timescale:

1. 27/04/2015
2. 01/04/2015

**Proposed Timescale:** 27/04/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Records had not been maintained of the satisfaction or not of the complainant. In addition, there was no documentation available to indicate if residents had been made aware of the appeals process.

**Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**

This was attended to and rectified immediately. This has since been addressed and the timeframe has been since 27th of February 2015.

**Proposed Timescale:** 27/02/2015

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Under Regulation 10 (2) you are required to:  
Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

**Action Required:**

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

**Please state the actions you have taken or are planning to take:**

1. Individual communication profiles will be developed taking in the communication of each resident. This will highlight to staff how to best support resident taking into account personalised communication needs.

**Proposed Timescale:** 30/05/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Under Regulation 10 (1) you are required to:  
Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

**Action Required:**

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

**Please state the actions you have taken or are planning to take:**

Individual communication profiles will be developed taking in the communication of each resident. This will highlight to staff how to best support resident taking into account personalised communication needs.

**Proposed Timescale:** 31/05/2015

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The admission policy did not outline the measures in place to protect residents from abuse by their peers.

**Action Required:**

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

**Please state the actions you have taken or are planning to take:**

The admissions policy is to be updated to include protection of resident from abuse by their peers

**Proposed Timescale:** 31/07/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The agreement for the provision of services did not outline the additional fees payable by residents.

**Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**

Inclusion of residents funding their own Holidays and Social outings will be put in their Service Agreement.

**Proposed Timescale:** 30/06/2015

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The premises were not designed or laid out to meet the aims and objectives of the service and the number and needs of residents.

**Action Required:**

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**

Funding application to Cork County Council (Capital Assistance Scheme)  
2. Meeting with ABI Ireland Property Manager on accommodation options & funding

Proposed Timescale:

1. 27/04/2015

2. 01/04/2015

**Proposed Timescale:** 27/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The designated centre did not adhere to best practice in achieving and promoting accessibility.

For example:

The hallways were too narrow for the needs of residents

The doorways were too narrow for use by the resident who required a wheelchair to mobilise

The placement of the house at the top of a steep hill did not promote independence for residents as expressed by them to inspectors.

**Action Required:**

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

**Please state the actions you have taken or are planning to take:**

1. Funding application to Cork County Council (Capital Assistance Scheme)
2. Meeting with ABI Ireland Property Manager on accommodation and funding options

Proposed Timescale:

1. 27/04/15
2. 01/04/15

**Proposed Timescale:** 27/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The requirements of Schedule 6 of the Regulations (Matters to be Provided for in Premises of Designated Centre) were not met.

For example:

-Adequate private and communal space was not provided

-There was inadequate space for social activities as the sitting room was in use as a bedroom for staff each night from 23.00hrs

-There was no bath in the centre

**Action Required:**

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

**Please state the actions you have taken or are planning to take:**

1. Funding application to Cork County Council (Capital Assistance Scheme)
2. Meeting with ABI Ireland Property Manager on accommodation and funding options

Proposed Timescale:

1. 27/04/15
2. 01/04/15

**Proposed Timescale:** 27/04/2015

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not include hazard identification and assessment of risks throughout the designated centre.

For example:

- the open front door and the low volume of the bell which indicated that residents' were exiting the building
- the use of a hot water bottle
- the access to the outside smoking area at night
- the storage of vinyl gloves
- open presses containing chemicals
- infection control procedures for washing kitchen and bathroom floors particularly in the presence of an infection
- residents smoking in their bedrooms
- residents going outside at night when staff are sleeping
- the window restrictors
- a current risk assessment for the safe storage of cigarettes
- risk of verbal or physical assault to members of the public
- risk of residents being abused in some way by members of the public
- residents falling when out on their own
- staffing levels for supervision
- lighted unsecured candle in a resident's bedroom
- the open fire in the sitting room

**Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**

1. Individual risk assessments for residents-

Actions carried out

- New alert system put in place with bell – completed
- Night time security check documented by staff - completed
- Risk assessment and new controls for residents smoking in bedrooms.- completed
- All Risk assessments to be completed in line with community practice

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not include the measures and actions in place to control all risks identified.

**Action Required:**

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**

Local risk management to be updated in relation to local and individual needs

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not include the measures and actions in place to control the unexplained absence of a resident.

**Action Required:**

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**

Risk Management policy to be reviewed to include unexplained absences of a resident

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

The risk management policy did not include the measures and actions in place to control accidental injury to residents, visitors or staff.

**Action Required:**

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

**Please state the actions you have taken or are planning to take:**

Risk Management policy to be reviewed to include accidental injury to residents, visitors or staff

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not include the measures and actions in place to control aggression and violence.

**Action Required:**

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

**Please state the actions you have taken or are planning to take:**

Risk Management policy to be reviewed to include aggression and violence

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy includes the measures and actions in place to control self-harm.

**Action Required:**

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

**Please state the actions you have taken or are planning to take:**

Risk Management policy to be reviewed to include self-harm



**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**

1. Review organisation's risk management policy to include review & learning from serious incidents
2. Introduce review of serious incidents or adverse events at shift handovers
3. Introduce review of serious incidents or adverse events at Team Meeting

Proposed Timescale:

1. 30/06/15
2. 27/02/15
3. 26/02/15

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Action Required:**

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**

Further advice from infection Control Nurse for and protocols revised accordingly

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Effective fire safety management systems were not in place in the centre.

**Action Required:**

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**

1. Issue to be raised with ABI Ireland Property Manager and investigation of options
2. Regional Manager to write to HSE in regards fire safety and funding availability

Proposed Timescale:

1. 01/03/15
2. 01/08/15

**Proposed Timescale:** 01/08/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The provider had not taken adequate precautions against the risk of fire.

- there was no fire panel/alarm system in place
- smoke alarms were not provided in all relevant areas
- smoking precautions and controls were not adequate in the centre as regards smoking, smoke alarms, lighting candles and the presence of an open fire.

**Action Required:**

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

**Please state the actions you have taken or are planning to take:**

1. Issue to be raised with ABI Ireland Property Manager and investigation of options
2. Regional Manager to write to HSE in regards fire safety and funding availability

Proposed Timescale:

1. 01/03/15
2. 01/08/15

**Proposed Timescale:** 01/08/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff had up to date knowledge and skills, appropriate to their role, to respond to behaviour that was challenging and to support residents to manage their behaviour

**Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**

Behavioural management training has been completed for staff on 17th of February and 30th of April with further training on week of the 19th of May 2015.

**Proposed Timescale:** 21/05/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff had receive training in the management of behaviour that was challenging including de-escalation and intervention techniques.

**Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

**Please state the actions you have taken or are planning to take:**

PIC to liaise with training dept. to secure training for all staff in the management of de-escalation..

**Proposed Timescale:** 02/10/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff had received training in the prevention of abuse.

**Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**

Prevention of Abuse training scheduled for the regional training which takes place from the 19th-22nd of May2015

**Proposed Timescale:** 22/05/2015

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents were not protected from all forms of abuse.

Some residents stated that they were apprehensive of their peers' behaviour.

Not all staff used a correct tone of voice towards the residents as reported by residents and staff.

**Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**

1. Meeting to occur with client to discuss issue raised during inspection in line with ABI Ireland policy
2. Residents meeting scheduled to make clients aware of their rights especially in regards protection from abuse.
3. Meeting to occur with staff member to discuss issue raised during inspection in line with ABI Ireland policy

Proposed Timescale:

1. 25th of February 2015
2. 31st of March 2015
3. 24th of February 2015

**Proposed Timescale:** 31/03/2015

### **Outcome 09: Notification of Incidents**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge had not given notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

**Action Required:**

Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

**Please state the actions you have taken or are planning to take:**

All notifications to be submitted in accordance with regulatory requirements

**Proposed Timescale:** 20/02/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge had not given notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

**Action Required:**

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

**Please state the actions you have taken or are planning to take:**

Notifications relating to alleged , suspected or confirmed abuse will be submitted in accordance with regulatory requirements, and investigated in accordance with ABI Ireland policy and national policy for the sector.

**Proposed Timescale:** 20/02/2015

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The centre did not provide appropriate health care for each resident, having regard to each resident's personal plan.

**Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**

Health Care Policy developed in line with Regulation 6. New template developed to document individual health care plans as per Regulation.

**Proposed Timescale:** 30/06/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all residents were able to access occupational health, psychology, behaviour specialist and speech and language therapy as often as required.

**Action Required:**

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**

1. Psychology is provided for monitoring support every 6 weeks and for behavioural specialist support.
2. Referrals to be forwarded for OT and SALT support from the community HSE services.

**Proposed Timescale:** 30/06/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

All residents attended the same GP and there was no indication that a choice of GP was offered on admission.

**Action Required:**

Under Regulation 06 (2) (a) you are required to: Ensure that a medical practitioner of the resident's choice or acceptable to the resident is made available.

**Please state the actions you have taken or are planning to take:**

Meeting with individual clients to review GP options and wishes.

**Proposed Timescale:** 31/05/2015

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The centre did not have appropriate and suitable practices in place relating to the storing, disposal and administration of medicines. This was required to ensure that out of date or returned medicines were stored in a secure manner that was segregated from other medical products and were disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Action Required:**

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Please state the actions you have taken or are planning to take:**

1. Out of date or expired medication to be stored in separate locked medication cabinet for disposal
2. Introduce protocol for the labelling for short-term medication (e.g. topical creams, powders, drops, etc)

Proposed Timescale:

1. 20/02/15
2. 30/04/15

**Proposed Timescale:** 30/04/2015

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The statement of purpose did not contain sufficient information on the management of complaints in the centre. The name of the complaints officer was not included and alternative complaints processes were not identified for residents. Fees outlined in the statement of purpose differed from the fees being charged (this was addressed during the inspection).

**Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**

Statement of Purpose to be updated, and forwarded to the Authority.

**Proposed Timescale:** 15/04/2015

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The designated centre was not fully resourced to ensure the effective delivery of care and support in accordance with the statement of purpose and the assessed needs of residents.

For example:

- residents were required to partially pay for a staff member to accompany them to, for example, concerts or on overnight shopping trips
- residents did not get out often enough in particular one resident who only gets out of the centre on average for two hours a week.
- occasionally only one staff member was on duty at weekends if the second staff member goes on sick leave. This limited residents' ability to go on weekend trips if that was their preference.
- according to the person in charge resources were not made available to undertake renovations to the house to ensure that it was suitable for all residents who live there.
- the person in charge had got a quotation for the installation of a fire panel/alarm system which would cost 2000 euro. These resources were not available to the centre.

**Action Required:**

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**

1. Revise the clients' service agreement to reflect charges applicable to the service.
2. Rota / staffing arrangements to be reviewed monthly at team meetings to ensure reflects the needs of residents
3. Rota/staffing arrangements to be reviewed on an ad hoc basis as and when the needs of the residents dictate.
4. Discussion/ Meeting to occur with ABI Ireland Property Manager in relation to fire safety

Proposed Timescale:

1. 30/06/15
2. 01/03/15
3. 01/03/15
4. 01/03/15

**Proposed Timescale:** 30/06/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**



Staff shortages impacted on the residents' ability to fulfil their goals and to go on outings as often as they would like.

**Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**

Rota and staffing levels to be reviewed monthly at team meetings to ensure needs of residents are met

**Proposed Timescale:** 01/03/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff had access to appropriate training and refresher training relevant to their role, for example:  
- buccal midazolam training.

**Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**

Staff member to complete training in buccal midazolam.

**Proposed Timescale:** 01/03/2015

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Policies in the centre were not reviewed at intervals not exceeding 3 years or where necessary, reviewed and updated in accordance with best practice.

**Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**

All organisational policies (under schedule 5) to be reviewed every 3 years in accordance with Regulations.

**Proposed Timescale:** 31/07/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all policies were adopted and implemented such as the medication management policy, the risk assessment policy and the policy on missing persons.

**Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**

Team Meeting arranged to discuss policies and ensure staff awareness.

**Proposed Timescale:** 30/07/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A summary of the services and facilities provided for residents in the centre was not available in the Resident's Guide.

**Action Required:**

Under Regulation 20 (2) (a) you are required to: Ensure that the guide prepared in respect of the designated centre includes a summary of the services and facilities provided.

**Please state the actions you have taken or are planning to take:**

Review & Update Resident's Guide

**Proposed Timescale:** 31/05/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The centre did not make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

For example:

- medication errors
- signatures for the administration of drugs

Tippex was used in part of a medication record

**Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**

1. All documentation in line with Schedule 3 to be available for inspection
2. Team Meeting arranged to discuss policies and ensure staff awareness.

Proposed Timescale:

1. 01/03/15
2. 30/07/15

**Proposed Timescale:** 30/07/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were not made available to the chief inspector:

For example:

A copy of notifications to the chief inspector, such as, records of missing person events.

**Action Required:**

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

**Please state the actions you have taken or are planning to take:**

All notifications submitted by the centre to be filed at the service and available to inspection

**Proposed Timescale:** 23/02/2015